Important Telephone Numbers

The table below lists frequently used services and their telephone numbers. You may obtain recipient information and ask questions by utilizing these services.

Service	Information available	Telephone number	Hours
Automated Voice Response (AVR) System (Recorded information)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247	24 hours/7 days a week
Commercial Eligibility Software and Forward Card Magnetic Stripe Readers	Recipient Eligibility*	Call Provider Services for a list of software and card reader vendors.	24 hours/7 days a week
Provider Services (Correspondents)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/eligibility/ billing: 8:30-4:30 (M, W-F) 9:30-4:30 (T) Pharmacy: 8:30-9:00 (M, W-F) 9:30-9:00 (T) 9:00-5:00 (Sat.)
Direct Information Access Line with Updates for Providers (Dial-Up)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 if you would like more information.	7:00-6:00 (M-F)

*Recipient eligibility information includes:

- Lock-in status.
- Medicare coverage.
- Medicaid managed care program name and telephone number.
- Privately-purchased managed care or other commercial health insurance coverage.
- Limited benefit information.

Order Form

Use this form to order additional complete copies of the Personal Care Handbook or separate handbook sections. You may also use this form to order a three-ring binder to hold your handbook(s).

Handbook Name	Quantity	Amount	Total
Personal Care Handbook, complete set		$34.50	
General Information section		$ 7.00	
Covered Services section		$ 6.25	
Prior Authorization section		$11.75	
Billing section		$ 9.50	
Wisconsin Medicaid Binder		$ 5.00	
Subtotal			$_____
5% Sales Tax			$_____
1/2% County Sales Tax (if applicable)			$_____
TOTAL ENCLOSED			$_____

If applicable, tax exempt number: _____

Company or organization: _____
Mailing address: _____
_____
Contact person: _____
Telephone number: _____

Send this form and a check or money order (made payable to EDS) for the full amount, including sales tax, to:
Medicaid Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Download Medicaid handbooks from the web

Wisconsin Medicaid handbooks are also available on the Internet. To download this handbook or its sections free of charge from the worldwide web, visit the Handbooks area of the Provider Publications section of the Medicaid web site at *www.dhfs.state.wi.us/medicaid*.

Ordering Wisconsin State Statutes & Wisconsin Administrative Code

You may purchase a copy of HFS 101-108, Wis. Admin. Code, and Wisconsin State Statutes from the address or telephone number at right.

To order from Document Sales:

Write:
Document Sales
Integrated Document Services
Department of Administration
P.O. Box 7840
Madison, WI 53707

Or call:
(608) 266-3358

Table of Contents

Preface

The Wisconsin Medicaid Personal Care Handbook is issued to personal care providers who participate in Wisconsin Medicaid. It contains information that applies to *fee-for-service* Medicaid providers. The information in this handbook applies to services provided to both Medicaid and BadgerCare recipients.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in Medicaid HMOs are entitled to at least the same benefits as Medicaid fee-for-service recipients; however, HMOs may establish their own requirements regarding coverage limitations, prior authorization, billing, etc. If you are a Medicaid HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used to resolve disputes regarding covered benefits under managed care arrangements.

The Personal Care Handbook consists of the following sections:

- General Information.
- Covered Services.
- Prior Authorization.
- Billing.

In addition to the Personal Care Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following subjects:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.
- Response to Claims Submission.

The Provider Rights and Responsibilities section of the All-Provider Handbook identifies specific responsibilities of a Wisconsin Medicaid provider. Refer to this section for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

Important:
The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Wisconsin regulation and law

- Regulation: Wisconsin Administrative Code, Rules of Health and Family Services, Chapters HFS 101 - 108.
- Law: Wisconsin Statutes: Sections 49.43 - 49.497 and 49.665.

Federal regulation and law

- Regulation: Title 42 CFR Parts 430 - 456 -- Public Health.
- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.

Wisconsin Medicaid handbooks and updates further interpret and implement these laws and regulations.

Wisconsin Medicaid handbooks and updates, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information are available at Wisconsin Medicaid's web site at: *www.dhfs.state.wi.us/medicaid*.

The DHFS contracts with a fiscal agent to provide health claims processing, communications, and other related services.

Coordination of Benefits

Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for any services covered by Wisconsin Medicaid.

Wisconsin Medicaid is the payer of last resort for any services covered by Wisconsin Medicaid according to HFS 106.03(7)(b), Wis. Admin. Code. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of its maximum allowable fee remaining after exhausting all other health insurance sources. Refer to the All-Provider Handbook for more detailed information on services requiring health insurance billing, cases in which providers should bill Wisconsin Medicaid *before* billing other forms of insurance, and the "Other Coverage Discrepancy Report (TPL–17)."

Medicare/Medicaid Dual Entitlement

General Information

Recipients covered under both Medicare and Medicaid are called dual entitlees.

Although services covered by Medicare do not require prior authorization (PA) from Wisconsin Medicaid, providers are strongly encouraged to obtain authorization prior to providing services. This will ensure Wisconsin Medicaid payment if Medicare denies coverage or if services exceed Medicare coverage.

Personal Care Services

If a recipient qualifies for Medicare home health services, Medicare will reimburse for a home health aide to provide hands-on personal care (e.g., bathing, dressing, grooming, and transfers) to maintain the recipient's health or facilitate treatment of the recipient's illness or injury. Agencies that Wisconsin Medicaid certifies to provide both home health and personal care services and personal care-only agencies follow different procedures regarding dual entitlees.

Home Health/Personal Care Agencies

If the recipient is a dual entitlee and Medicare covers the service, Medicare-enrolled providers are required to send claims to Medicare *before* billing Wisconsin Medicaid, according to HFS 106.03(7)(b), Wis. Admin. Code.

If Medicare covers the service provided to a dual entitlee but the claim is denied, Medicare-enrolled providers should indicate a Medicare disclaimer code in the appropriate field/item on the Wisconsin Medicaid claim form. Claims denied by Medicare due to provider billing error must be corrected and resubmitted to Medicare before being sent to Wisconsin Medicaid. Refer to Item 84 of the UB-92 Claim Form Instructions in Appendix 2 of this section for the appropriate Medicare disclaimer code.

Personal Care-Only Agencies

Wisconsin Medicaid will not reimburse for personal care services which would be reimbursed by Medicare. Personal care-only agencies are not Medicare-enrolled providers. Therefore, they are required to notify all personal care recipients about Medicare coverage and:

- Provide the recipient with the "Notice to Wisconsin Medicaid Recipients Regarding This Personal Care Agency" form. Refer to Appendix 1 of this section for this form.
- Have the recipient or legally responsible person review and sign this form.
- Give the recipient a copy and keep the original form in the recipient's file.

If the recipient is eligible for Medicare home health services and your agency is not enrolled by Medicare to provide home health services, you are required to either:

- Coordinate care with a Medicare-enrolled home health agency so your agency

provides only those personal care hours that exceed Medicare's home health coverage.

- Discharge the recipient from your care.

Disposable Medical Supplies

Medicare may pay for disposable medical supplies (DMS) under Part B coverage. Medicare-enrolled providers are required to bill Medicare for these supplies. If you are not certified to bill Medicare, the recipient will need to obtain the supplies from a different Medicare-enrolled provider, such as a rehabilitation agency, pharmacy, or other medical equipment or supplies vendor.

If a provider submits claims to Wisconsin Medicaid for services that Medicare would pay, Wisconsin Medicaid may recoup any related payments it made on a postpayment basis.

Use Coverage Determination Software to Ensure Appropriate Billing

All Medicaid-certified home health and personal care providers receive coverage determination software (CDS) upon certification and are required to use it for recipients who are eligible for both Medicare and Wisconsin Medicaid. This computer software helps providers identify when they should bill Medicare before billing Wisconsin Medicaid for dual entitlees. It also allows you to access help screens which explain Medicare home health policy. The printed results from the CDS determination provide documentation to meet the federal requirement that services covered by Medicare are not paid by Wisconsin Medicaid.

Requirements for the use of CDS for recipients who are entitled to both Medicare and Wisconsin Medicaid are reviewed below:

- Use the CDS before your agency provides Wisconsin Medicaid services.
- Use the CDS when a recipient's condition or status changes, potentially making the recipient eligible for Medicare home health coverage.
- Keep a printed copy of the results of the software's determination on file and on the agency's premises for audit purposes.

If you are unable to access the CDS with your computer system or have computer problems, you can use the Worksheet for Home Health Coverage Determination Questions from the CDS Manual to reach the same results. Photocopy the final eligibility determination from Appendix B of the CDS Manual for your files.

Technical questions about the software should be directed to:

United Wisconsin Proservices, Inc.
401 W. Michigan Street
Milwaukee, WI 53202

Telephone: (800) 822-8050
Fax: (414) 226-6033

Policy and billing questions should be directed to:

Medicaid Provider Services
(800) 947-9627 or (608) 221-9883

Qualified Medicare Beneficiary-Only Recipients

Qualified Medicare Beneficiary-Only (QMB-Only) and Qualified Medicare Beneficiary-Nursing Home (QMB-NH) recipients are only eligible for Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. If Medicare denies services, Wisconsin Medicaid does not cover them.

Refer to the All-Provider Handbook for more information on QMB-Only recipients.

All Medicaid-certified home health and personal care providers receive coverage determination software (CDS) upon certification and are required to use it for recipients who are eligible for both Medicare and Wisconsin Medicaid.

Billed Amounts

Providers are required to bill for each date of service that care was provided.

Providers are required to bill their usual and customary charge for services provided. Refer to the General Information section of this handbook for more information on reimbursement.

Billing Dates of Service

Providers are required to bill for each date of service that care was provided. When billing, a maximum of four dates of service may be entered on one detail line, given the following conditions:

- All dates of service are in the same calendar month.
- Procedure codes are the same for all four dates of service.
- The charges for the procedures are identical for each date of service.
- The quantity of units is the same for all dates of service.

The quantity entered for each detail line represents the number of units for each day, multiplied by the number of days of service. Similarly, the charges for each detail line represent the charges for that service multiplied by the number of days of service. Refer to Appendix 3 of this section for an example of series billing.

If two or more detail lines must be used for the same procedure/revenue code (e.g., when billing more than four identical dates of service in a calendar month), the additional dates of service that can be billed to the same procedure/revenue code must be indicated on a separate detail line. The appropriate units and charges for those dates of service must also be included.

Each detail line must always include the correct units and charges for the dates on that line or the claim will be denied.

Billing Units of Service

Personal Care and Travel Time

For personal care services and travel time, one hour of service is equivalent to one unit of service and one-half hour of service is equivalent to one-half unit of service. Personal care providers should bill in one-half hour increments.

When calculating the number of units that should be billed (Item 46 on the UB-92 claim form), total the number of personal care hours or travel time hours for that date of service, and round up or down according to the following guidelines:

- If the time spent giving care is a maximum of 1 to 30 minutes in length, round the time up to 30 minutes and bill the service as a quantity of 0.5 unit.
- If the time spent giving care is more than 30 minutes in length, then round up or down to the nearest 30-minute increment using the common rules of rounding.

Follow the same rounding rules when calculating travel time. Refer to Appendix 4 for a chart of rounding guidelines. Refer to the Covered Services chapter of the Covered Services section of this handbook for more information on travel time.

Registered Nurse Supervisory Visits

Registered nurse supervisory visits for personal care (procedure codes W9906 or W9044) must be billed as a quantity of one unit, regardless of the duration of the visit. For example, a supervisory visit lasting 20 minutes and a supervisory visit lasting 60 minutes would both be billed a quantity of 1. Refer to the Covered Services section of this handbook for more information on personal care supervisory visits.

Procedure Codes

All Personal Care Services

Providers are required to use Wisconsin Medicaid procedure codes (W codes) to bill personal care services, travel time and RN supervisory visits. Refer to Appendix 4 for a current list of allowable procedure codes and descriptions. Claims or adjustments received without the appropriate codes are denied.

Disposable Medical Supplies

Providers are required to use the HCFA Common Procedure Coding System (HCPCS) codes for billing disposable medical supplies (DMS). Covered DMS codes can be found in the DMS Index, which is sent to providers periodically, or on the Wisconsin Medicaid web site at *www.dhfs.state.wi.us/medicaid*. Claims or adjustments received without the appropriate codes are denied.

Billing Place of Service and Type of Service on Claim Form

UB-92 Claim Form

Personal care services are billed on the UB-92 claim form. Place of service (POS) and type of service (TOS) codes are not required. However, providers should keep in mind that place of service and type of service codes are required on the Prior Authorization Request Form (PA/RF), elements 16 and 17.

HCFA 1500 Claim Form

Use the HCFA 1500 claim form to bill DMS. Both place of service and type of service codes are required. Refer to Appendix 4 for allowable place of service and allowable type of service codes.

Providers are required to use Wisconsin Medicaid procedure codes (W codes) to bill personal care services, travel time and RN supervisory visits.

Guidelines for Billing Services

Prior authorization does not guarantee reimbursement.

Billing for Personal Care and Travel Time Services Not Prior Authorized

Wisconsin Medicaid allows Medicaid-certified providers to be reimbursed for the first 50 hours of medically necessary personal care and travel time services per calendar year, per recipient in any combination of prior authorized or non-prior authorized hours. All prior authorized and non-prior authorized services reimbursed in the calendar year, regardless of date of service or when the claim is submitted, count toward this 50-hour threshold. Therefore, providers should take care to delay submitting claims for prior authorized personal care hours until *after* claims for non-authorized hours have been finalized.

Providers should bill all personal care and travel time services without prior authorization (PA) on a separate claim form from those services with PA.

Billing for Prior Authorized Services

Prior authorization does not guarantee reimbursement. Provider certification, recipient eligibility, and medical necessity, as well as all other state and federal requirements, must be met before the claim is paid, according to HFS 107.02(3)(i), Wis. Admin. Code.

Listed below are some guidelines for billing Wisconsin Medicaid prior authorized services:

- The PA number indicated on the Prior Authorization Request Form (PA/RF) must be on all claims for dates of service that are between the grant date and expiration date of the approved PA/RF.
- Reimbursement will be allowed only for direct care or travel hours actually used, within rounding guidelines, even if the PA allows for additional time.
- Reimbursement will be allowed only for dates of service between the grant date and expiration date indicated on the approved PA/RF.
- Only one PA number is allowed per claim form. Services authorized under separate PA requests should be billed on separate claim forms.
- Medicaid-certified home health/personal care agencies can bill for both home health and personal care services on the same claim form if the corresponding PA includes both personal care worker and home health procedure codes.

Billing for Multiple Recipients in a Single Location

If personal care services are provided to more than one recipient at a single location, providers should only bill for the actual time spent by the PCW (rounded to the nearest 30-minute increment). Billing examples follow:

- *Services performed in sequence*. If you are providing bathing and dressing services to a husband and wife in the same home, bill seperately for the actual time spent (within rounding guidelines) providing services for each recipient. The total time billed cannot exceed the actual time spent giving care, within rounding guidelines.
- *Services performed simultaneously*. Bill only once for tasks that are simultaneously performed for more than one recipient at a time. Examples include cleaning, laundry, grocery shopping, meal preparation, and travel time.
  - √ Housekeeping example: If it takes two hours to provide cleaning, laundry, and meal preparation for a husband and wife who are both Wisconsin Medicaid recipients and live in the same home, bill Medicaid one hour for the husband and one hour for the wife. Billing two hours for each recipient is

duplicate billing and would be subject to recoupment.

√ Travel time example: If you are providing personal care services for two recipients residing in a Community Based Residential Facility (CBRF), add your travel time to and from the CBRF, round to the nearest 30-minute increment, and bill for one recipient only. Billing the total travel time to each recipient is duplicate billing and would be subject to recoupment. Refer back to the Billing Units of Service portion of this section for more information.

Community Services Deficit Reduction Benefit

Eligible agencies wishing to participate in the Community Services Deficit Reduction Benefit (CSDRB) program must submit completed certification forms and cost reports developed by the Department of Health and Family Services (DHFS).

Wisconsin Statutes authorize Wisconsin Medicaid to make federal financial participation funds (FFP) available to counties, local health departments, and tribal agencies to reimburse these agencies for operating deficits incurred in providing personal care and selected other non-institutional services to Wisconsin Medicaid recipients. Operating deficits are defined as the difference between program costs and the Wisconsin Medicaid claims paid amount (after certain adjustments).

Eligible agencies wishing to participate in the Community Services Deficit Reduction Benefit (CSDRB) program must submit completed certification forms and cost reports developed by the Department of Health and Family Services (DHFS). Costs reported by participating agencies must be based on allowable cost and cost-finding principles as instructed by the DHFS. These costs are evaluated by the DHFS for reasonableness and accuracy. Benefits are paid retroactively based on information provided in the cost reports, subject to DHFS review and limitations.

For information on this program or to send in completed certification forms and cost reports, contact the CSDRB coordinator at:

CSDRB Coordinator
10 East Doty Street
Suite 210
Madison, WI 53703
(888) 322-1006

Claims Submission

Each Medicaid-certified provider is responsible for the truthfulness, accuracy, timeliness, and completeness of claims whether billing Wisconsin Medicaid themselves or through a billing service.

Providers using a billing service should provide Wisconsin Medicaid instructions to the billing service. Always provide the billing service an accurate list of the hours and dates of service provided. Each Medicaid-certified provider is responsible for the truthfulness, accuracy, timeliness, and completeness of claims whether billing Wisconsin Medicaid themselves or through a billing service, according to HFS 106.02(9)(e), Wis. Admin. Code. Claims may be submitted on paper or electronically.

Paper Claims

Personal Care Services

Providers are required to use the UB-92 claim form when submitting paper claims to Wisconsin Medicaid. Personal care claims submitted on paper claim forms other than the UB-92 will be denied. Refer to appendices 2 and 3 of this section for UB-92 completion instructions and for an example of a UB-92 claim form.

Disposable Medical Supplies

Disposable medical supplies (DMS) provided by personal care providers must be billed on the HCFA 1500 claim form using the HCFA Common Procedure Coding System. Wisconsin Medicaid provides the DMS Index to all Medicaid-certified personal care providers. Refer to the DMS Index for procedure codes and coverage limitations. Wisconsin Medicaid denies DMS claims that are submitted on any form other than the HCFA 1500 claim form. Refer to appendices 5 and 6 for HCFA 1500 completion instructions for DMS and for an example of a HCFA 1500 claim form for DMS.

Obtaining UB-92 and HCFA 1500 Forms

Wisconsin Medicaid does not supply the UB-92 or HCFA 1500 claim forms. They may be obtained from a number of commercial form suppliers. One such source is the Standard Register, which can be contacted at:

Standard Register
P.O. Box 6248
Madison, WI 53716
(608) 222-4131

Submitting Claims

Completed UB-92 and HCFA 1500 claim forms should be mailed to:

Wisconsin Medicaid
6406 Bridge Road
Madison, WI 53784-0002

Electronic Claim Forms

Both the UB-92 and HCFA 1500 claim forms are available in electronic formats. Wisconsin Medicaid provides free software for billing claims electronically. If you currently use the free PACE or EZ-Link electronic billing software and have technical questions, please contact the United Wisconsin Proservices, Inc. customer service desk at (800) 822-8050.

For policy questions, contact Provider Services at (800) 947-9627 or (608) 221-9883. For data entry questions within the software, contact the Electronic Media Claims (EMC) unit at (608) 221-4746, Ext. 3037 or 3041.

Electronic claim submission eliminates manual handling of claims, reducing errors and allowing faster turn-around time. As with paper claims, electronically submitted claims can be processed and paid correctly only if all data supplied is accurate and complete. Providers are responsible for the accuracy of all data submitted via electronic claims.

For more information on electronic claims, refer to the All-Provider Handbook, or contact

the Electronic Media Claims (EMC) department at:

EMC Department
Wisconsin Medicaid
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746, Ext. 3037 or 3041

Follow-up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid, according to HFS 106.03(3)(b)2, Wis. Admin. Code.

Providers are responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid.

Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Refer to Appendix 7 for a partial list of Explanation of Benefit codes (denial codes) and how to avoid common claim denials.

Wisconsin Medicaid takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to Wisconsin Medicaid. Refer to the All-Provider Handbook for detailed information about:

- The Remittance and Status Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good Faith claims filing procedures.

Glossary of Common Terms

Activities of daily living (ADL)
Activities of daily living are activities relating to the performance of self care, including dressing, feeding or eating, grooming, and mobility.

Coverage determination software (CDS)
Coverage determination software is computer software that providers are required to use for recipients who are eligible for both Wisconsin Medicaid and Medicare. The software helps providers identify when they should bill Medicare before billing Wisconsin Medicaid.

Community Services Deficit Reduction Benefit (CSDRB)
Community Services Deficit Reduction Benefit is a Wisconsin Medicaid program that makes federal financial participation funds available to counties, local health departments and tribal agencies to reimburse these agencies for funds they expend in excess of Wisconsin Medicaid reimbursement for personal care and selected other non-institutional services.

Date of service
The date of service is the calendar date on which a specific medical service is performed.

Disposable medical supplies (DMS)
Disposable medical supplies are medically necessary items which have a very limited life expectancy and are consumable, expendable, disposable, or nondurable.

Dual entitlee
A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both, is a dual entitlee.

Dually certified agency
A dually certified agency is an agency that is Medicaid-certified to provide both home health and personal care services.

HCFA 1500
The HCFA 1500 is the Health Care Financing Administration claim form used for billing DMS.

Medicare
Medicare is a national health insurance program for people 65 years of age and older, certain younger people with disabilities, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Personal care worker (PCW)
A personal care worker is an individual employed by a personal care provider certified under HFS 105.17, Wis. Admin. Code, or under contract to the personal care provider to provide personal care services under the supervision of a registered nurse.

Provider
A personal care provider is a home health agency, county department, independent living center, tribe, or public health agency that has been certified by Wisconsin Medicaid to provide personal care services to recipients and to be reimbursed by Wisconsin Medicaid for those services.

Place of service (POS)
The place of service is the place where the service was performed. For Wisconsin Medicaid prior authorization and billing purposes, it is identified by a single-digit code.

Qualified Medicare Beneficiary Only (QMB-Only)
QMB-Only recipients are only eligible for Medicaid coverage of the coinsurance and the deductibles for Medicare-allowed claims.

Registered nurse (RN)
A registered nurse is a person who holds a current Wisconsin license as a registered nurse under ch. 441, Wis. Stats., or, if practicing in another state, is registered with the appropriate licensing agency in that state.

Supervision
Supervision of personal care services is required to be performed by a qualified RN who reviews the Plan of Care (POC), evaluates the recipient's condition, and observes the personal care worker (PCW) performing assigned tasks at least every 60 days. Supervision requires intermittent face-to-face contact between supervisor and assistant and regular review of the assistant's work by the supervisor according to HFS 101.03(173), Wis. Admin. Code. Supervisory review includes:

- A visit to the recipient's home.
- Review of the PCWs daily written record.
- Discussions with the physician of any necessary changes in the POC, according to HFS 107.112(3)(c), Wis. Admin. Code.

Travel time
Travel time is the time spent traveling to and from the recipient's residence and the previous or following personal

care appointment, the personal care worker's residence, or the provider's office.

Type of service (TOS)
The type of service identifies the general category of medical services. For Wisconsin Medicaid prior authorization and billing purposes, it is identified by a single-digit code.

UB-92
The UB-92 is the claim form used for personal care services.

Usual and customary charge
The provider's charge for providing the same service to persons not entitled to Medicaid benefits is the usual and customary charge.

Index